Pathways to Integrated Health Care Delivery Systems

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Integrated Health Care Delivery Models and Multi-payer Delivery Systems Study Committee

November 19, 2013

Des Moines, Iowa

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Reforming Health Care Delivery

- Where do you want to go?
- What strategies can help you get there?

NASHP

- 26-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- Academy members
  - Peer-selected group of state health policy leaders
  - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues

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Where do you want to go?

Background Image by Dave Cutler, Vanderbilt Medical Center (http://www.mc.vanderbilt.edu/lens/article/?id=216&pg=999)

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Patient-Centered Primary Care COLLABORATIVE

Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies
Patient-Centered	**Supports patients and families** to manage & organize their care and participate as **fully informed partners** in health system transformation at the **practice, community, & policy** levels	• **Dedicated staff help patients navigate system** and create care plans • **Focus on strong, trusting relationships** with physicians & care team, open communication about decisions and health status • Compassionate and culturally sensitive care
Comprehensive	**A team of care providers** is wholly accountable for patient's **physical and mental health** care needs – includes prevention and wellness, acute care, chronic care	• Care team focuses on '**whole person**' and **population health** • Primary care could **co-locate** with behavioral and/or oral health, vision, OB/GYN, pharmacy • Special attention is paid to **chronic disease** and complex patients
Coordinated	Ensures care is **organized across all elements** of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health	• Care is **documented and communicated** across providers and institutions, including patients, specialists, hospitals, home health, and public health/social supports • Communication and connectedness is enhanced by **health information technology**
Accessible	Delivers **consumer-friendly services** with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	• More efficient appointment systems offer **same-day or 24/7 access** to care team • Use of **e-communications and telemedicine** provide alternatives for face-to-face visits and allow for after hours care
Committed to quality and safety	Demonstrates commitment to quality improvement through use of **health IT** and other tools to ensure patients and families make informed decisions	• **EHRs, clinical decision support, medication management** improve treatment & diagnosis. • Clinicians/staff monitor **quality improvement goals** and use data to track populations and their quality and cost outcomes

Potential Impacts

Patients are more likely to seek the right care, in the right place, and at the right time

Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated

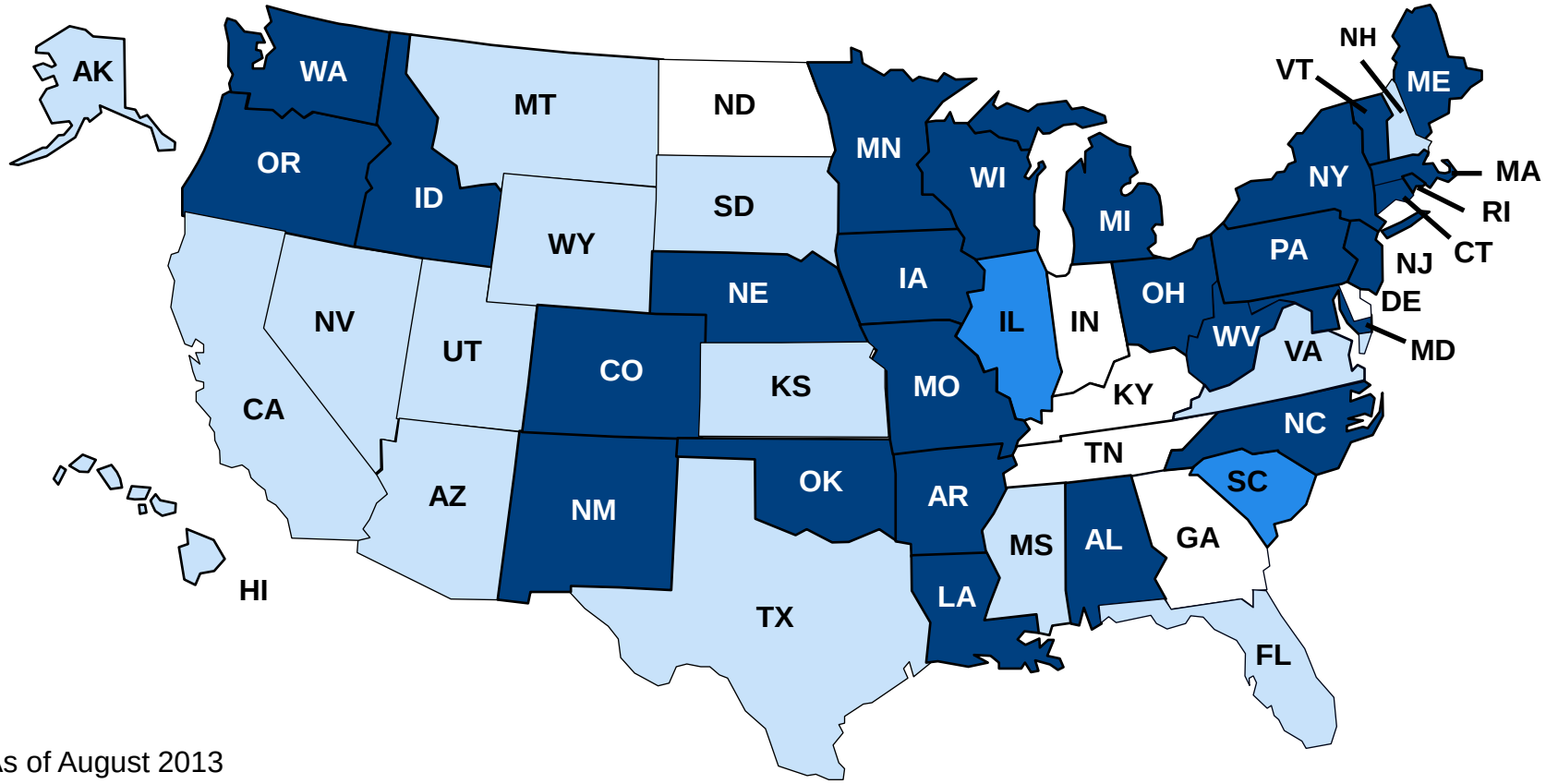
Providers are less likely to order duplicate tests, labs, or procedures

Better management of chronic diseases and other illness improves health outcomes

Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

Cost savings result from:
- Appropriate use of medicine
- Fewer avoidable ER visits, hospitalizations, & readmissions

State-Based Medical Home Initiatives



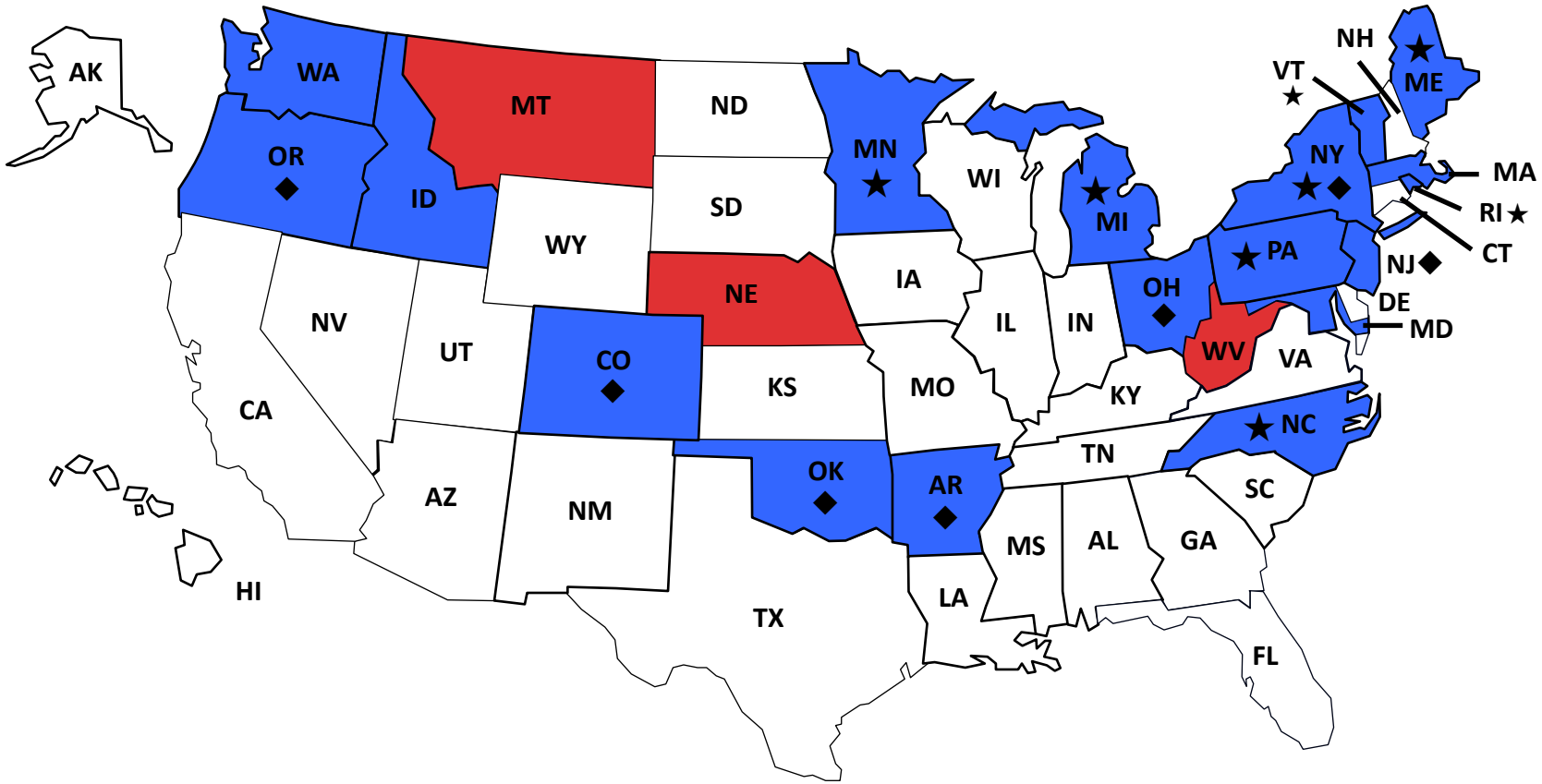
As of August 2013

- Medical home activity (44 states and Washington, D.C.)
- Making medical home payments (29 states)
- Payments based on provider qualification standards (27 states)

New support for primary care practices

- Payments for ongoing medical home costs
- Payment incentives for performance
- Managed care contracts
- Provider adoption of good practices
- Info to providers on performance/patients
- Funding and/or technical assistance for HIT/HIE, i.e. Registry, EHR, eRx
- Care coordination

Multi-Payer Medical Homes



Multi-payer planning activity underway (3)

Multi-payer payments to medical homes underway (18)

★ Participating in Multi-payer Advanced Primary Care Practice Demonstration (8: ME, MI, MN, NY, NC, PA, RI, VT)

◆ Participating in Comprehensive Primary Care Initiative (CPCi) (7: AR, CO, NJ, NY, OH, OK, OR)

SOURCE: National Academy for State Health Policy. "Medical Home and Patient-Centered Care."
Available at: www.nashp.org/med-home-map. As of August 2013.

Key state policy features of multi-payer medical home models

- Legislation, executive branch leadership helpful, but more often, initiatives are voluntary in nature.
- Anti-trust protection offered by the state helpful, but not required.
- New payments to primary care practices typically include monthly capitation, performance, and often start-up costs.
- Payments aligned with practices achieving new medical home qualifications, i.e. NCQA PCMH
- Practice transformation activities.
- Data analytics including feedback to practices is key.
- Independent evaluations.

Expanding Medical Home Capacity through Multi-disciplinary Teams

Key model features:

- Practice teams—often shared among practices
- Payments to teams and qualified providers
- Teams are based in a variety of settings
- Community developed, teams vary from region to region

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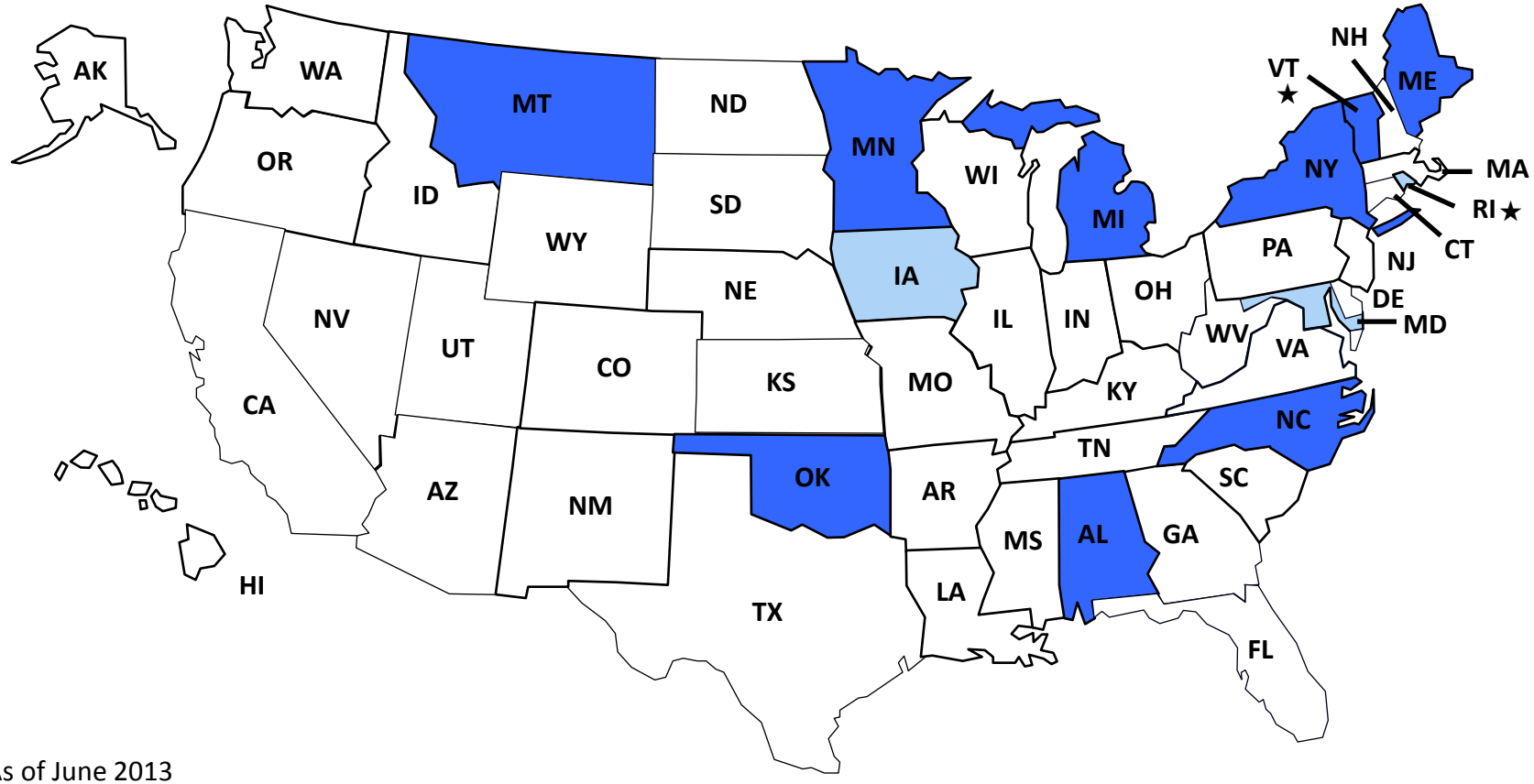
Shared Practice Team Models



As of June 2013

Shared Practice Team Programs—includes Medicaid support (9: AL, ME, MI, MN, MT, NY, NC, OK, VT)

Planning Activity (3: IA, MD, RI)

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Mary Takach and Jason Buxbaum. 2013. "Care Management for Medicaid Enrollees Through Community Health Teams." The Commonwealth Fund.

A Tale of Two Shared Practice Team Models

- Vermont **vs.**

1. $350k per 5 FTE team based on payer market share
2. Blind to insurance status; public utility; referrals from practices & communities
3. Focus on prevention as well as chronic disease management

- Maine

1. $2.95 PMPM Medicaid; $3 PMPM Medicare; $0.30 PMPM commercial payers
2. Focused on high risk insured patients using risk stratification
3. Focus on chronic disease management

Building "Health Home" Neighborhoods

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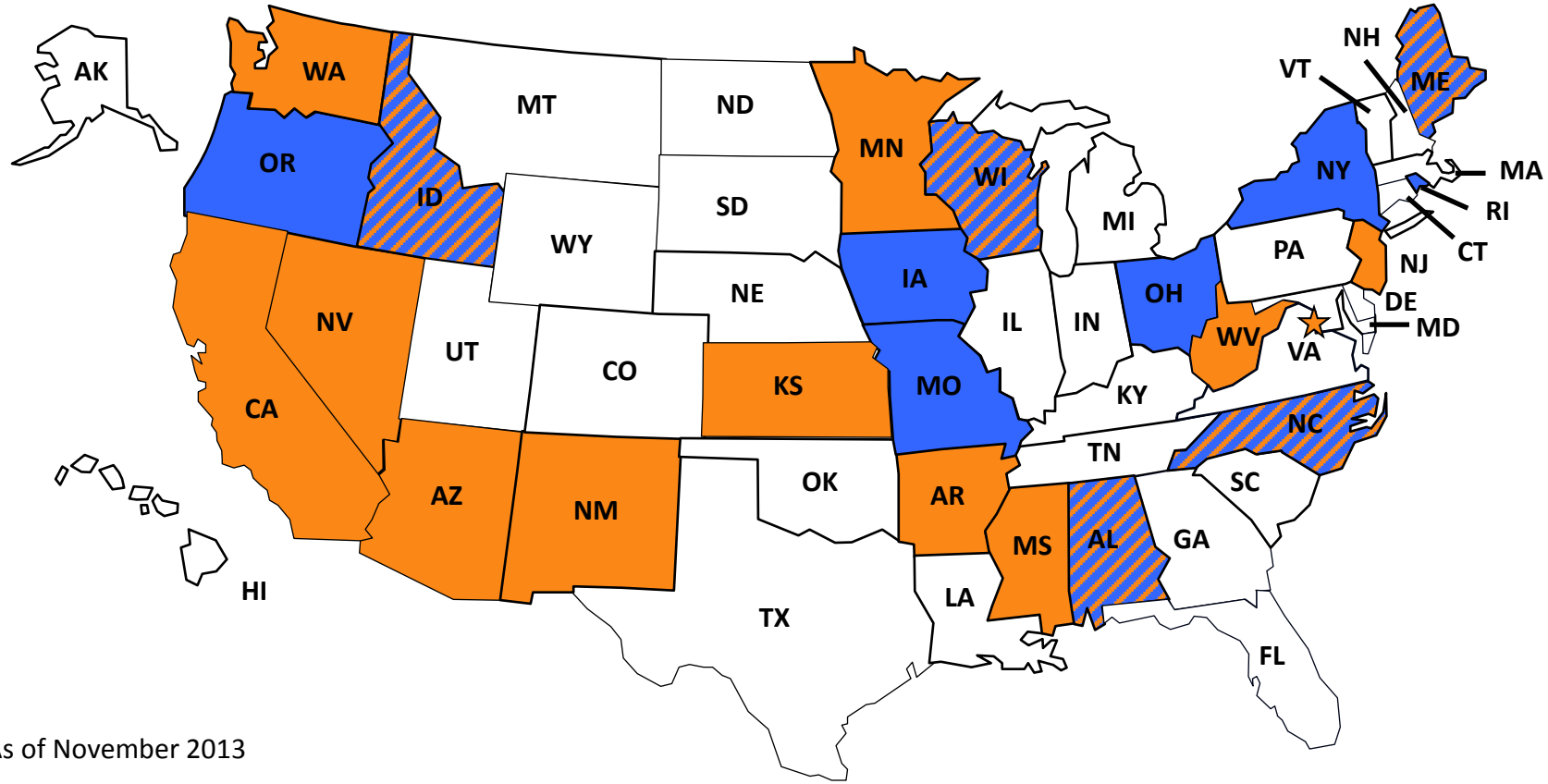
ACA Section 2703 Health Home Activity



As of November 2013

Approved State Plan Amendment(s) (11)

Planning Grant (17)

Note: *States with stripes have both*

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http://www.nashp.org/med-home-map

Medical Homes vs. Health Homes

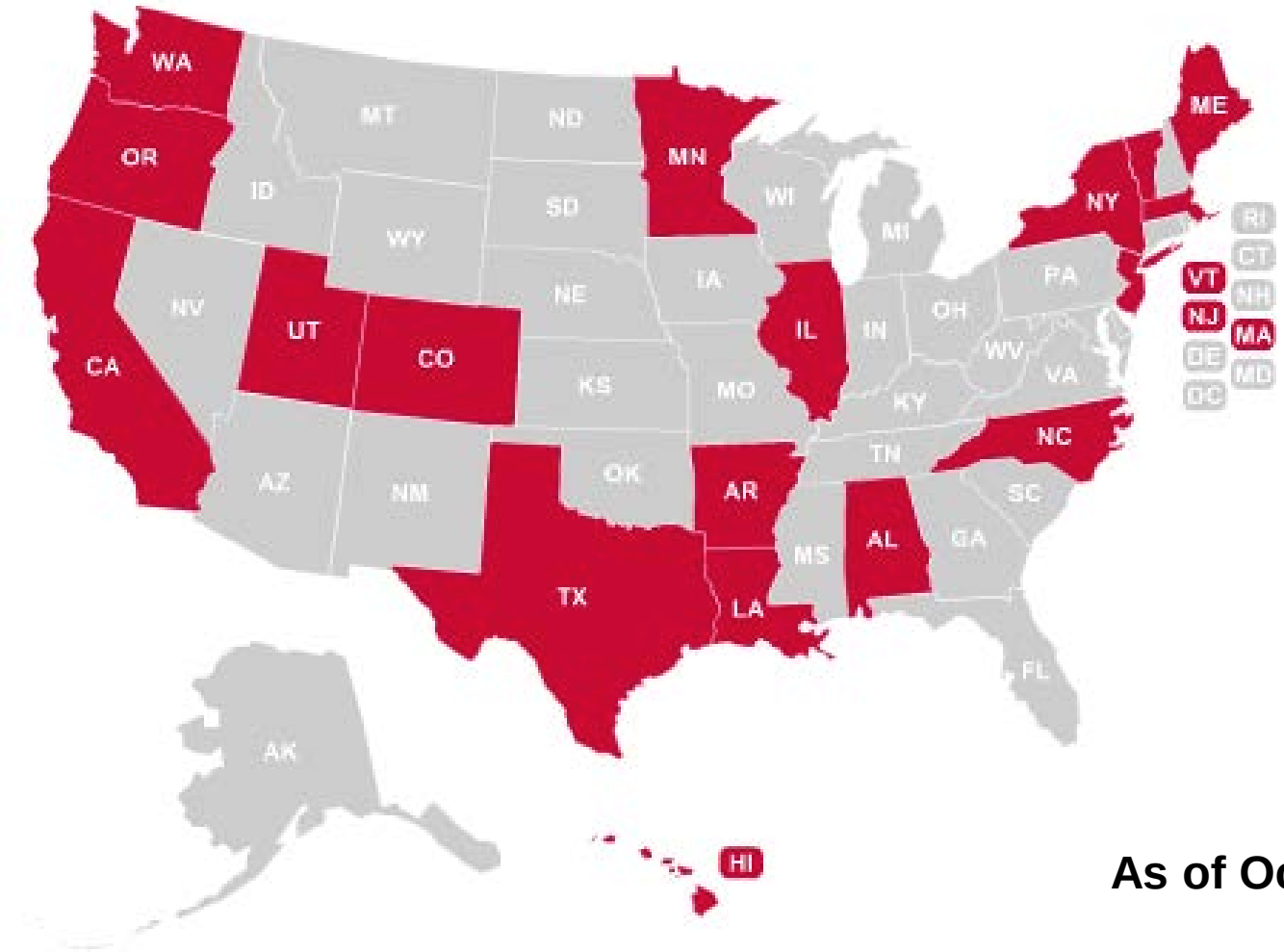
Medical Homes

- Designed for everybody
- Primary care provider-led
- Primary care focus
- No enhanced federal Medicaid match

2703 Health Homes

- Designed for eligible individuals with a serious mental illness and/or specific chronic physical conditions
- Primary care provider is key, but not necessarily the lead
- Focus on linking primary care with behavioral health and long-term care
- Eight-quarter 90 percent federal Medicaid match
- Significant increase in financial support to providers

NASHP's State Accountable Care Activity Map



As of October 2013

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Key state policy features of ACOs

1. Strong Primary Care Foundation
2. Accountability for Quality of Care, Patient Care Experiences, and Total Costs for a defined population of patients
3. Informed and Engaged Patients
4. Payment That Reinforces and Rewards High Performance
5. Innovative Payment Methods and Organizational Models
6. Timely Monitoring, Data Feedback, and Technical Support for Improvement

Integrated care health system models

Key model features:

- High-performing primary care providers
- Emphasis on coordination across providers in the health care system
- Shared goals & risk for a community of patients
- Population health management tools
- Health information technology & exchange
- Engaged patients

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Oregon Coordinated Care Organizations (CCOs) Payment Model

- Authorized by the legislature in 2012 via SB 1580
- 15 CCOs are operating in communities in Oregon
- Each CCO receives a *fixed global budget* for physical/mental/ (ultimately dental care) for each Medicaid enrollee
  - CCOs must have the capacity to assume risk
  - Implement value-based alternatives to traditional FFS reimbursement methodologies
- CCOs to coordinate care and *engage enrollees* & providers in health promotion
- Meet key quality measurements while reducing spending growth by 2% over the next 2 years

www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx

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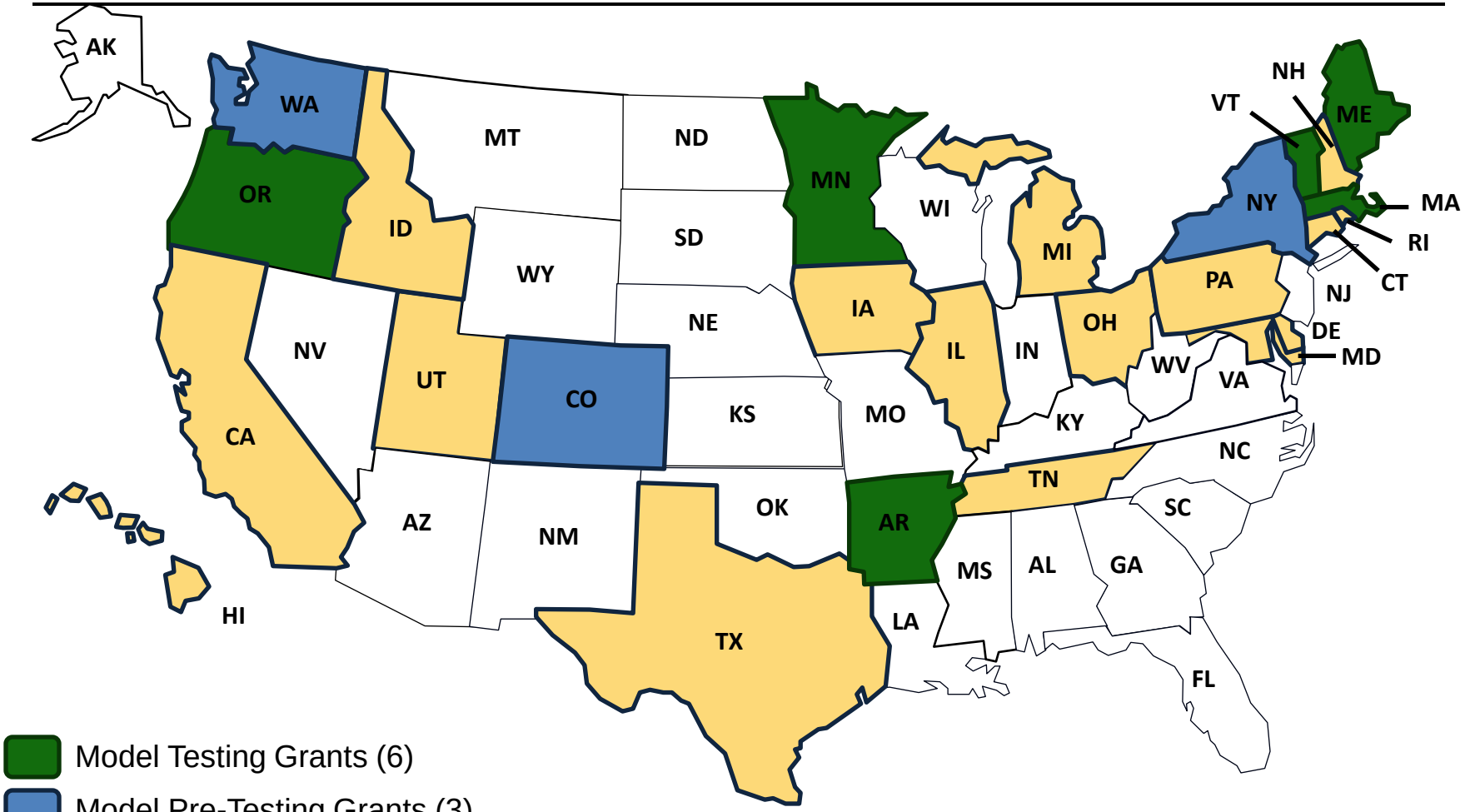
State Innovation Models (SIM) Initiative



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State Innovation Models: Colorado

- Three strategies for supporting integration of behavioral health into primary care
  1. Invest in data, measurement, and payment infrastructure
  2. Expand and leverage existing structures for learning and communication
  3. Provide funding for practices to finance cost of integration
- Key stakeholders in CO have already formed Health Extension Service supporting primary care redesign and collaboration

State Innovation Models: Minnesota

Phase One	January 2013 – June 2013	• Implementation of nine accountable care organization (ACO) contracts under the Medicaid Health Care Delivery Systems Demonstration in alignment with other payers in the state
Phase Two	July 2013 – June 2014	• Second round of ACO contracts to be awarded, expanding the number of Medicaid enrollees and other populations served • ACOs will also receive resources and infrastructure support for measurement, quality improvement, data exchange, and practice transformation
Phase Three	July 2014 – June 206	• Continued testing of and infrastructure support for ACOs • Existing Community Care Teams will be expanded to 15“Accountable Communities for Health,” bringing together ACO providers and organizations representing a range of each community’s population and service needs

State Innovation Models: Vermont

- Vermont will test three payment models:

1. **Population-based Performance**: Shared Savings ACO Models
2. **Coordination-based Performance**: Bundled Payment Models
3. **Provider-based Performance**: P4P Models

Key Takeaways

- Primary care redesign essential to improving value in health care
- Medical homes and accountable care organizations provide models to improve primary care
- Change is slow and hard and requires upfront $$
- Multi-payer financing is key to system-wide change.
- Early evaluations of medical home are promising, but *significant* short term savings are not likely.
- Accountable care shows promise in producing reducing costs, payment model not likely sustainable.
- Integrated health systems are the goal
- Affordable Care Act provides significant resources

For More Information

Please visit:

- www.nashp.org
- www. nashp.org/med-home-map
- www.nashp.org/state-accountable-care-activity-map
- www.statereforum.org
- www.pcpcc.org

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